U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 10 May 2007

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In the Matter of:

G. A., widow of
E. A., deceased,
Claimant,

Case No. 2004-BLA-06795

v.

TCH COAL COMPANY/
A.T. MASSEY,
Employer/Carrier, and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party in Interest.

.....

Appearances:

William Lawrence Roberts, Esq., Pikeville, KY
For the Claimant

Natalee Gilmore, Esq., Jackson Kelly, PLLC, Lexington, KY
For the Employer

Before: PAMELA LAKES WOOD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a survivor's claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §901, *et. seq.* ["the Act"] filed by Claimant G.A. ["Claimant"] on August 5, 2003 based upon the death of her husband, deceased miner E.A. ["Miner"]. The putative responsible operator is T C H Coal Company. ["Employer"] which is insured through A.T. Massey ["Carrier"]. Benefits are currently being paid by the Black Lung Disability Trust Fund.

Part 718 of title 20 of the Code of Federal Regulations is applicable to this claim, as it was filed after March 31, 1980, and the regulations amended as of December 20, 2000 are

applicable, as this claim was filed after January 19, 2001.[1] 20 C.F.R. §718.2. In *National Mining Assn. v. Dept. of Labor,* 292 F.3d 849 (D.C. Cir. 2002), the U.S. Court of Appeals for the D.C. Circuit rejected the challenge to, and upheld, the amended regulations with the exception of several sections.[2] The Department of Labor amended the regulations on December 15, 2003 for the purpose of complying with the Court's ruling. 68 Fed. Reg. 69929 (Dec. 15, 2003).

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, including all evidence admitted and arguments submitted by the parties. Where pertinent, I have made credibility determinations concerning the evidence.

STATEMENT OF THE CASE

On August 5, 2003, Claimant filed the current application for black lung survivor's benefits under the Act [survivor's claim], based upon the May 29, 2003 death of her husband, the Miner, at the age of 80. (DX 2).[3] The Miner had previously filed a claim in 1985 that was last denied in 1987. (DX 1). On January 29, 2004, the District Director issued a Schedule for the Submission of Additional Evidence, which indicated the preliminary conclusions that the Claimant would be entitled to benefits if a decision were issued at that time and that TCH Coal Company (self-insured thru A.T. Massey) was the responsible operator liable for the payment of benefits. (DX 24). On June 8, 2004, the District Director issued a Proposed Decision and Order, Award of Benefit—Responsible Operator. (DX 32). Following Employer's timely (June 17, 2004) request for a formal hearing (DX 33), on September 10, 2004, this matter was referred to the Office of Administrative Law Judges for a hearing (DX 39).

A formal hearing was held on October 12, 2005. Claimant was the only witness to testify. (Tr. 14-18). At the hearing, Director's Exhibits 1 through 41, Claimant's Exhibits 1 through 7, and Employer's Exhibits 1 through 9 and 11 through 16 were admitted into evidence.[4] (Tr. 5-6, 7-12, 19-27, 28). Employer's Exhibit 10 and Exhibits 17 through 24 were not in existence, but were to be submitted posthearing, with possible responsive evidence to be submitted by the Claimant.[5] (Tr. 28-30). Employer's Exhibit 25 was excluded. (Tr. 18-19). Further, I determined that I would allow more than one report by the same doctor, and I found good cause for doing so, to avoid requiring the physicians having to prepare new reports.[6] (Tr. 7-12). Several evidentiary issues remained, however, and additional briefing was requested. (Tr. 30-36). At the conclusion of the hearing, the record was held open for a period of 90 days for the

[1] Section and part references appearing herein are to Title 20 of the Code of Federal Regulations unless otherwise indicated.

[2] Several sections were found to be impermissibly retroactive and one which attempted to effect an unauthorized cost shifting was not upheld by the court.

[3] Director's Exhibits, Claimant's Exhibits, and Employer's Exhibits are referenced as "DX", "CX", and "EX", respectively, followed by the exhibit number. References to the hearing transcript appear as "Tr." followed by the page number.

[4] Although DX 1, the Miner's claim, was admitted, evidence from that claim may only be considered to the extent it is in compliance with the evidentiary limitations (i.e., it has been designated by the parties or is otherwise admissible, such as a treatment note.)

[5] Although the exhibits were initially admitted, I changed my ruling when I learned that the exhibits were not present. (Tr. 27-28.)

[6] That ruling was addressed further in the Order Clarifying and Modifying Record of December 15, 2005.

submission of post-hearing evidence, after which the parties were to submit briefs or written closing arguments within 30 days, subject to extension by stipulation. (Tr. 37-38).

Following the hearing, both parties submitted additional evidence, and I issued three Orders: (1) an Order Clarifying and Modifying Record of December 15, 2005; (2) an Order to Show Cause of January 18, 2006; and (3) a Supplemental Order Clarifying and Modifying Record of March 21, 2006. Those Orders are incorporated by reference herein. The Order of March 21, 2006 clarified the record, provided that the evidence exceeding the evidentiary limitations (including rebuttal exhibits submitted in response to medical reports) be stricken, closed the record, and ordered that briefs or written closing arguments be filed within 30 days, subject to extension by stipulation. Claimant's brief/closing argument was filed on May 12, 2006 and Employer's brief/closing argument was filed on June 6, 2006; both briefs are accepted as timely filed. Claimant filed a "Motion to Render Decision" on June 20, 2006.

In view of the above, a decision will be made based upon the record as set forth in the an Order Clarifying and Modifying Record of December 15, 2005, as modified by the Supplemental Order Clarifying and Modifying Record of March 21, 2006 and as modified below. Thus, in rendering a decision, I will not consider DX 13 in part and DX 17 in part; CX 4, 5, 6, 10; EX 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, which were either not admitted or were stricken. With respect to EX 3 and EX 8 [Dr. Roggli's report and deposition], the portion that went beyond review of the slides was stricken, and the same rule is applicable to Dr. Caffrey's report and deposition (DX 17 and EX 7), as discussed below. The attachments to EX 8 [Dr. Roggli's deposition], as well as the attachments to EX 7 [Dr. Caffrey's deposition], EX 9 [Dr. Repsher's deposition], and EX 10 [Dr. Ghio's deposition] were stricken; however, the c.v.s will be allowed as attachments. Thus, the record consists of DX 1 in part, DX 2 through 12, DX 13 in part, DX 14 through 16, DX 17 in part, DX 18 through 41, CX 1 through 3, CX 7 through 9, EX 1, EX 2, EX 3 in part, EX 4 through EX 6, and EX 7 through 10 [without attachments except for c.v.s and with portions stricken]. **SO ORDERED.**

ISSUES/STIPULATIONS

The sole issue for resolution by this tribunal is:

Causation: Whether the Miner's death was due to pneumoconiosis.

(DX 39; Tr. 36-37). In addition, issues concerning the validity of the regulations were preserved for appellate purposes. (DX 39-2, Tr. 36-37).

At the hearing, Employer withdrew the issues of timeliness, miner, post-1969 employment, dependency, survivor, existence of pneumoconiosis, and its causal relationship with coal mine employment. (Tr. 36). It was agreed that total disability was listed in error when the case was transmitted. (Tr. 36-37).

With respect to length of coal mine employment, the parties stipulated to at least 20 years of coal mine employment. (Tr. 37).

"Responsible Operator" was not listed as an issue. (DX 39). T C H Coal Co. is the properly named responsible operator.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background and Employment History

Claimant testified that she was married to the Miner in 1945 and they continued to be married until the time of his death on May 29, 2003. (Tr. 14). She did not remarry. (Tr. 14). At the time of his death, she was the only one dependent on him. (Tr. 17-18). During his lifetime, the Miner worked as a coal miner for "[t]hirty some" years and he performed all kinds of jobs, including shoveling coal, running the motor, and working as a brakeman. (Tr. 15). When he returned from his work in the mines, his clothing was full of dust. (Tr. 15). He last worked in the coal mines in 1984. (Tr. 15). At that time, he was employed by T C H Coal in Millard, Kentucky. (Tr. 17). He was treated by Dr. Adkins for over twenty years. (Tr. 16). Dr. Swafford treated him for his prostate. (Tr. 17) The Miner was hospitalized at Pikeville Methodist Hospital for his breathing during the later years of his life, and he had previously been hospitalized in Lexington at St. Joseph Hospital. (Tr. 16). The Miner took medicine for a heart condition and she was told that he had a heart attack when he passed away. (Tr. 18). The autopsy was performed by Dr. Dennis. (Tr. 18). The Miner smoked "some" but he quit in about 1972; she doubted that he had smoked for as long as 20 years. (Tr. 16, 17). When he worked in the mines, he chewed tobacco. (Tr. 16-17).

Death Certificate

According to the death certificate, signed by Russell Roberts, the Pike County Coroner, the Miner died on May 29, 2003, at his residence, at the age of 80. The immediate cause of death was listed as "M.I." [myocardial infarction], with a duration of minutes, due to (or as a consequence of) "C.O.P.D. [chronic obstructive pulmonary disease] due to Anthracosilicosis," with a duration of years, due to (or as a consequence of) "CA [cancer] of Prostate." (DX 10). The death certificate was prepared without benefit of the autopsy results.

Medical Records

Medical records from the Methodist Hospital of Kentucky/Pikeville Methodist Hospital reflect that the Miner was treated for a variety of conditions, including chronic obstructive pulmonary disease, between 1985 and 2003. (DX 1, 14). He also was injured in an automobile accident in December 1989 in which he sustained a concussion, neck and chest injury, and multiple contusions (including cardiac contusion), and he had another automobile accident in October 2002, resulting in multiple contusions. (DX 14). He was diagnosed with adenocarcinoma of the prostate in October 2002 by pathologist James A. Dennis, M.D., following a transurethral resection of the prostate. *Id.* In November 3, 1990 and October 9, 1991 notes, it was mentioned that he chewed tobacco. (DX 14). Most of the records for this hospital indicate that the Miner was a non smoker but do not elaborate further. (DX 1, 13, 14). However, a History and Physical by Mark J. Swifford, D.O. dated October 7, 2002, indicated that the Miner "had a 60-pack year history of tobacco, he quit 20 years ago." (DX 14-9).

Several documents from the Miner's claim (both medical records and physician opinion reports) also address his smoking history and other matters. A medical record from the Methodist Hospital (specifically, a Consultation by R. V. Mettu, M.D.) relating to the Miner's October 29, 1985 admission noted that the Miner "smoked for about ten years and quit smoking 40 years ago." (DX 1-4). However, an August 28, 1985 letter to the Department of Labor from Dr. Mettu, who conducted an examination for the Department on the same date, indicated that the Miner "denied any history of smoking" and the examination report also indicates that he never smoked. (DX 1-30). That same record also indicates that the Miner worked 25 years in the mines, out of which 22 were underground. *Id.* A report from Dr. Bruce Broudy relating to his examination of the Miner on August 9, 1985 also listed him as a nonsmoker. (DX 1-56). That record indicated a 30-year coal mining history of which more than 18 years were underground, running a motor, brake, and drill. *Id.*

Medical records from St. Joseph Hospital, Lexington, Kentucky relate to his treatment in June 1990 for residuals from the first automobile accident. Treatment included cardiac catheterization. A history taken on June 25, 1990, at the time of his admission, indicated that he had a cigarette history of "1 ppd" [pack per day] and quit 15 years ago. (DX 16-28). Discharge diagnoses included chest pain of unclear etiology, possibly angina; cardiomyopathy of questionable etiology (alcohol, excessive); and chronic obstructive pulmonary disease (pneumoconiosis, status post tobacco abuse). (DX 16-4). On discharge, he was reassured that the "cath findings were good with only minor non-flow restrictive single vessel coronary artery disease." (DX 16-6).

Medical Evidence

In addition to the death certificate and medical/hospital records discussed above, the medical evidence consists of the following (which will be discussed below when relevant):

X-ray Interpretations:

1. X-ray of 10/03/91, K.B. Kim, DX 14 [Claimant initial]
2. X-ray of 08/09/85, P. Wheeler, EX 4 [Employer initial]
3. X-ray of 08/09/85, W. Scott, EX 4 [Employer initial]

Pulmonary Function Studies:

1. B. Broudy, 08/09/85, DX 1/EX 6 [Claimant/Employer initial]
2. R. Mettu, 08/28/85, DX 1/EX 5 [Claimant/Employer initial]

Arterial Blood Gases:

1. R. Penman, 07/27/84, DX 1, p. 90 [Claimant initial]
2. E. Massabni, 11/16/01, DX 15, p. 24 [Claimant initial]
3. B. Broudy, 08/09/85, DX 1/EX 6 [Employer initial]
4. R. Mettu, 08/28/85, DX 1/EX 5 [Employer initial]

Medical Reports:

1. J.A. Dennis, 09/20/05, CX 3; 10/31/05, CX 8 [Claimant initial]
2. D.A. Adkins, 03/09/04, DX 13-3; 11/01/05, CX 9 [Claimant initial]
3. L. Repsher, 03/15/04, EX 1 [Employer initial]
4. A. Ghio, 03/21/04, EX 2 [Employer initial]

Autopsy Evidence:

1. J.A. Dennis, 05/30/03, DX 11, 13 [Report by Autopsy Prosector, DX 13-2 stricken]
2. V. Roggli, 09/15/05, EX 3 [Rebuttal] [portion that goes beyond slide review stricken]
3. C.F. Delara, 09/15/05, CX 1 [Claimant initial] [only slide review to be considered]
4. P.R. Caffrey, 02/20/04, DX 17 [Employer initial] [only slide review to be considered]

Depositions:

1. L. Repsher, 03/15/04, EX 9 (w/o attachments except for c.v.)[7]
2. P.R. Caffrey, 08/10/05, EX 7 (w/o attachments except for c.v.) [portion that goes beyond slide review stricken]
3. V. Roggli, 07/15/05, EX 8 (w/o attachments except for c.v.) [portion that goes beyond slide review stricken]
4. A. Ghio, 10/11/05, EX 10 (w/o attachments except for c.v.)

DISCUSSION AND ANALYSIS

Evidentiary Limitations

My consideration of the medical evidence is limited under the regulations, which apply evidentiary limitations to all claims filed after January 19, 2001. 20 C.F.R. §725.414. Section 725.414, in conjunction with Section 725.456(b)(1), sets limits on the amount of specific types of medical evidence that the parties can submit into the record. *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1-47 (2004) (en banc), BRB No. 03-0615 BLA (June 28, 2004) (en banc) (slip op. at 3), citing 20 C.F.R. §§725.414; 725.456(b)(1). Under section 725.414, the claimant and the responsible operator may each "submit, in support of its affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, no more than one report of an autopsy, no more than one report of each biopsy, and no more than two medical reports." *Id.*, citing 20 C.F.R. §725.414(a)(2)(i),(a)(3)(i). In rebuttal of the case presented by the opposing party, each party may submit "no more than one physician's interpretation of each chest X-ray, pulmonary function test, arterial blood gas study, autopsy or biopsy submitted by" the opposing party "and by the Director pursuant to §725.406." *Id.*, citing 20 C.F.R. §725.414(a)(2)(ii), (a)(3)(ii). Following rebuttal, each party may submit "an additional statement from the physician who originally interpreted the chest X-ray or administered the objective testing," and, where a

[7] While the journal articles may be admissible, I find that they add little to Dr. Repsher's testimony and they will remain stricken. The summary of an article is also stricken.

medical report is undermined by rebuttal evidence, "an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence." *Id.* "Notwithstanding the limitations" of section 725.414(a)(2),(a)(3), "any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence." *Id.,* citing 20 C.F.R. §725.414(a)(4). Medical evidence that exceeds the limitations of Section 725.414 "shall not be admitted into the hearing record in the absence of good cause." *Id.,* citing 20 C.F.R. §725.456(b)(1).

The parties cannot waive the evidentiary limitations, which are mandatory and therefore not subject to waiver. *Phillips v. Westmoreland Coal Co.*, 2002-BLA-05289, BRB No. 04-0379 BLA (BRB Jan. 27, 2005) (unpub.) (slip op. at 6).

The Benefits Review Board discussed the operation of these limitations in its en banc decision in *Dempsey, supra.* First, the Board found that it was error to exclude CT scan evidence because it was not covered by the evidentiary limitations and instead could be considered "other medical evidence." *Dempsey* at 5; see 20 C.F.R. § 718.107(a) (allowing consideration of medical evidence not specifically addressed by the regulations). Second, the Board found that it was error to exclude pulmonary function tests and arterial blood gases derived from a claimant's medical records simply because they had been proffered for the purpose of exceeding the evidentiary limitations. *Dempsey* at 5. Third, the Board held that state claim medical evidence is properly excluded if it contains testing that exceeds the evidentiary limitations at § 725.414. In so holding, the Board noted that such records did not fall within the exceptions for hospitalization or treatment records or for evidence from prior federal black lung claims. *Dempsey* at 5. Fourth, on the issue of good cause for waiver of the regulations, the Board noted that a finding of relevancy would not constitute good cause and therefore records in excess of the limitations offered on that basis, and on the basis that the excluded evidence would be "helpful and necessary" for the reviewing physicians to make an accurate diagnosis, were properly excluded. *Dempsey* at 6. Finally, the Board stated that inasmuch as the regulations do not specify what is to be done with a medical report that references inadmissible evidence, it was not an abuse of discretion to decline to consider an opinion that was "inextricably intertwined" with excluded evidence. *Dempsey* at 9. Referencing *Peabody Coal Co. v. Durbin*, 165 F.3d 1126, 21 BLR 2-538 (7th Cir. 1999), the Board acknowledged that it was adopting a rule contrary to the common law rule allowing inadmissible evidence to be considered by a medical expert, because "[t]he revised regulations limit the scope of expert testimony to admissible evidence." *Dempsey* at 9-11.

As the Board noted in *Dempsey*, the regulations specifically allow evidence from a prior claim to be considered in connection with a later claim, so that a determination may be made whether there has been a material change in conditions since the time of the prior claim, 20 C.F.R. §725.309(d)(1); however, there is no such provision applicable to survivor's claims that would allow consideration of the evidence developed in the miner's claims, absent a finding of good cause. Consistent with the above limitations and the Board's decision in *Dempsey,* other administrative law judges have generally excluded evidence developed in connection with a miner's claim from consideration in a surviving spouse's claim to the extent that the limitations have been exceeded, unless the case involves a consolidated miner's claim and survivor's claim.

However, in *Keener v. Peerless Eagle Co.*, BRB No. 05-1008 BLA (BRB Jan. 30, 2007) (en banc), the Board held that even if the cases are consolidated, there should be separate records for a miner's claim and a survivor's claim.

In *Keener,* the Board also addressed the issue of autopsy evidence. In that case, the claimant relied upon the autopsy prosector Dr. Plata's report as his report of autopsy pursuant to §725.414(a)(2)(i). The Board found that the Employer could submit the report of Dr. Oesterling, which reviewed the autopsy slides, as its affirmative autopsy report (even though Dr. Oesterling did not examine the miner's body after death), and that it could also submit Dr. Bush's autopsy rebuttal report (based on macroscopic and microscopic observations) for the purpose of rebutting Dr. Plata's autopsy report; however, the portions of Dr. Bush's report that were based on review of clinical evidence of record (as opposed to a review of the autopsy slides) should have been redacted as constituting a medical opinion not within the evidentiary limitations. With respect to the latter point, the Board found that the administrative law judge impermissibly relied on Dr. Bush's complete opinion instead of the portion of the opinion related to a slide review. As applied to the instant case, *Keener* allows the admission of Dr. Caffrey's autopsy report and Dr. Roggli's autopsy rebuttal report, but to strike the portions of Dr. Roggli's report (and deposition) going beyond the slide review, consistent with my March 21, 2006 Supplemental Order Clarifying and Modifying record. Likewise, Dr. Caffrey's report and Dr. Delara's report will be considered as affirmative autopsy reports and will not be considered to the extent that they go beyond such.

In *Brasher v. Pleasant View Mining, Inc.,* BRB No. 05-0570 BLA (BRB April 28, 2006), slip op. at 6, the Board noted that, where a physician's reports constitute two separate written assessments of the miner's pulmonary condition at two different times, an administrative law judge may properly decline to consider them as a single medical report under the evidentiary limitations. As applied to this case, *Brasher* supports my decision to allow more than one report by the same physician if such could be restated as a single report but to disallow multiple reports when they constitute separate medical opinions based upon separate examinations. However, it arguably goes against my decision to exclude supplemental reports. Thus, rather than admitting the supplemental reports as "rebuttal" to medical opinions, which are not provided for under the regulations, the reports could be admissible to the extent that they merely constitute an extension of the previous reports based upon consideration of additional evidence. Such a report and supplemental report could be reformatted into a single report addressing all of the admissible evidence. Upon review of the multiple supplemental reports issued by the two physicians issuing initial medical opinions for the Employer (Drs. Repsher and Ghio), I am unable to find that they fit within the *Brasher* rule as they are essentially rebuttal reports directed toward particular medical opinions. However, the two supplemental reports by Drs. Adkins and Dennis, the two physicians rendering initial medical opinions for the Claimant, merely state that they have not changed their opinions based upon review of additional evidence, including medical records. I find that those two supplemental reports (CX 8 and 9) are admissible, and I therefore modify my ruling to so provide.

In this case, there were significant issues concerning the evidentiary record in view of the evidentiary limitations. However, as discussed above, they were resolved by my previous Orders, and I do not find a basis for modifying my previous rulings other than as stated above.

To the extent that inadmissible evidence may have been referenced in otherwise admissible medical reports, I will not consider that evidence. In such case, I will strike the inadmissible references and consider the reports to the extent not inextricably intertwined. In so stating, I do not mean that I intend to go back and mark the stricken evidence with a marker; rather, I will not take into consideration the stricken portions in rendering a decision. This matter is discussed further, in context, below.

Causation of Death

The Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence is evenly balanced, the claimant must lose. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 281 (1994). In *Greenwich Collieries*, the Court invalidated the "true doubt" rule, which gave the benefit of the doubt to claimants. Thus, in order to prevail in a black lung case, the claimant must establish each element by a preponderance of the evidence.

In order to prevail in a survivor's claim, a claimant must establish that the miner had pneumoconiosis arising out of his coal mine employment which caused, contributed to, or hastened his death.

As noted above, the parties have stipulated to the presence of pneumoconiosis arising out of coal mine employment. That stipulation relates essentially to the simple coal worker's pneumoconiosis found by all of the pathologists based upon the autopsy slides. In order to be eligible for benefits, Claimant must therefore establish that the Miner's death was due to pneumoconiosis. In considering that issue, I will take into consideration whether the Miner's chronic obstructive pulmonary disease may be deemed to be legal pneumoconiosis.

Since the claim was filed after January 1, 1982, the issue of death due to pneumoconiosis is governed by §718.205(c), as amended, which states, in pertinent part:

> For the purpose of adjudicating survivor's claims filed on or after January 1, 1982, death will be considered to be due to pneumoconiosis if any of the following criteria is met:
>
> (1) Where competent medical evidence establishes that pneumoconiosis was the cause of the miner's death, or
>
> (2) Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or
>
> (3) Where the presumption set forth at §718.304 is applicable.[8]
>
> (4) However, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that

[8] The presumption in section 718.304 relates to complicated pneumoconiosis.

pneumoconiosis was a substantially contributing cause of death.

(5) Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death.

20 C.F.R. §718.205(c).

Medical Opinion Evidence

Mindful of the above criteria, I will consider the medical opinions and pathology evidence on the issue of the cause of the Miner's death.

Autopsy Report by James A. Dennis, Prosector

The Autopsy Report was prepared by Pikeville Methodist Hospital pathologist James A. Dennis, M.D. and was later revised (DX 11, 13). After providing a Gross Description of the Cardiovascular System and the Respiratory System (which, inter alia, noted macules measuring greater than 3 to 5 cms.) and a Microscopic Description of the autopsy slides, Dr. Dennis reached the following Pathological Diagnosis based upon the autopsy conducted on May 30, 2003, in a report printed on July 30, 2003 and initialed, and filed with the district director on August 5, 2003:

I. CARDIOVASCULAR SYSTEM:
   1. Coronary artery disease moderate to severe with 95% occlusion of the right coronary artery, focal, no [] evidence of acute myocardial infarction.[9]
   2. Left ventricular hypertrophy.

II. RESPIRATORY SYSTEM:
   1. Pulmonary congestion, moderate with focal bronchopneumonia.
   2. Anthracosilicosis, moderate with plaque formation, fibrosis and silica particle deposition within black pigment clusters with associated emphysematous change panlobular.
   3. Anthracosilicosis moderate to severe.

SUMMARY AND DISCUSSION

There is no evidence of progressive massive fibrosis. The anthracosilicosis present is moderate to severe. The patient died as a result of a probable cardiac arrhythmia and pulmonary congestion and edema along with bronchopneumonia.

The patient has an underlying pulmonary pathology of anthracosilicosis, moderate to severe.

[9] In the original, there is a large space between the "no" (which is flush to the margin) and the "evidence" (which is indented) apparently due to a spacing error.

(DX 11-2). However, the second page of the autopsy report was revised and, in a report printed on February 27, 2004, filed with the district director on March 15, 2004, the spacing error in the first Cardiovascular System item was corrected (although the spacing on the second Respiratory System item was messed up) and the first sentence and the last sentence under SUMMARY AND DISCUSSION were revised to read:

> There is evidence of progressive massive fibrosis. . . .
>
> The patient has an underlying pulmonary pathology of anthracosilicosis, moderate to severe, and progressive massive fibrosis.

(DX 13-5.) Apart from the finding of progressive massive fibrosis in the second report, that is not present in the first, and a correction relating to the heart weight, the reports are the same. Given the reference to macules of 3 to 5 cms. in both reports, coupled with Dr. Dennis' later report, it is clear that he intended the changes, and I will therefore accept the later version of the autopsy report.

Rebuttal/Slide Review and Deposition by Dr. Victor L. Roggli

As noted earlier, Dr. Victor Roggli, a board-certified pathologist, provided a rebuttal report and deposition for the purpose of rebutting Dr. Dennis' autopsy report.[10] (EX 3, 8). Both the report and deposition went far beyond a simple slide review. My consideration of the report and deposition will be confined to their rebuttal from a pathological basis of the autopsy report.

The pathological portion of Dr. Roggli's report stated the following:

> Received are eighteen glass slides. . . . Sections of lung parenchyma show centrilobular emphysema with hypertensive vascular changes, focal organizing pneumonia, pulmonary edema, and corpora amylacea. There is minimal pigment deposition, and a rare coal dust macule is identified in blocks Q and R. In addition, subpleural fibrosis is present in block M and peribronchial fibrosis in block P. The latter two are associated with numerous birefringent particles and the pattern is consistent with silica induced pulmonary fibrosis. There is no evidence of progressive massive fibrosis. Other findings at autopsy include patchy myocardial fibrosis and moderate to severe atherosclerosis.
>
> Review of the medical record in this case reveals . . . [remainder of sentence stricken]. At autopsy there was evidence of simple coal worker's pneumoconiosis. [Next sentence stricken.] It is unlikely that his degree of coal worker's pneumoconiosis would have reduced his capacity to perform his coal mine employment prior to his death. Furthermore, it is unlikely that coal worker's pneumoconiosis had any significant [e]ffect on his clinical course prior to death. Finally, coal worker's pneumoconiosis in my opinion did not contribute

[10] Dr. Ghio stated at his deposition that Dr. Roggli was nationally and internationally recognized as an expert in pneumoconiosis. (EX 10 at 23-24.) At his deposition, Dr. Roggli testified that (with a colleague) he recently wrote a chapter on pneumoconioses in a textbook on pulmonary pathology (published in 2005). (EX 8 at 6-7).

> nor in any way hasten [Miner's] death. These opinions are provided with a reasonable degree of medical certainty.

(EX 3).

At his deposition, Dr. Roggli further discussed his slide review and also went into matters relating to his review of other medical records, which is not admissible here.[11] He testified:

> Q. Doctor, what must you find pathologically to diagnose simple coal workers' pneumoconiosis?
>
> A. Well, the hallmark of coal workers' pneumoconiosis is a structure called the coal dust macule. And that consists of an area of expansion of the interstitium of the lung by dust-laden macrophages.
>
> And that irregularly shaped area is surrounded by dilated alveolar spaces, which has been referred to as focal emphysema. And those, that combination of findings, is called a coal dust macule.
>
> Q. What must you find to diagnose complicated coal worker's pneumoconiosis pathologically?
>
> A. Well, complicated coal workers' pneumoconiosis typically involves changes that we refer to as – as progressive massive fibrosis, where you have areas, at least 2 centimeters in diameter, of irregularly shaped particulate material, abundant pigment, and haphazardly arranged collagen bundles, sometimes with necrosis in the center.
>
> And this characteristic picture is referred to as progressive massive fibrosis, or complicated coal workers' pneumoconiosis.

(EX 8 at 7-8). When asked about the Miner's specific case, he stated that the lung findings included centrilobular emphysema, associated hypertensive vascular changes, areas of organizing pneumonia, areas of pulmonary edema and corpora amylacea (intra-alveolar accumulations of protein material probably the result of pulmonary edema in which the fluid was reabsorbed), very little pigment deposition, two coal dust macules (one each on blocks Q and R), subpleural fibrosis (block M), and peribronchial fibrosis (block P), and numerous birefringent particles with polarizing microscopy (in blocks M and P); however, there was no evidence of massive fibrosis. (EX 8 at 10). The heart showed patchy scarring, indicative of a previous myocardial infarct, and he had moderate to severe atherosclerosis. (*Id.* at 10-11.) Dr. Roggli further stated that the pigment deposition, the coal dust macules, the subpleural fibrosis in block M, and the peribronchial fibrosis in block P were all due to occupational exposure to coal dust. (*Id.* at 11.)

Based upon his review of the autopsy report, Dr. Roggli said that the autopsy prosector did not describe the changes of progressive massive fibrosis. (*Id.* at 11-12). However, he did not

[11] While I have not considered the attachments to the deposition, except for Dr. Roggli's c.v., it is worth noting that one of the attachments relates to a different decedent. (EX 8, second attachment labeled # 2.)

specifically address Dr. Dennis' finding (in both versions of the autopsy report) that: "Macules measuring greater than 3 to 5 cms are appreciated." (DX 13-2; DX 11-1). Of Dr. Dennis' findings on autopsy, he stated that the anthracosilicosis with plaque formation, fibrosis, silica particle deposition within black pigment clusters, and anthracosilicosis moderate to severe were related to coal dust inhalation. (*Id.* at 20).

Autopsy Report by Dr. C.F. Delara

Dr. C.F. Delara, a board-certified pathologist, reviewed the 18 autopsy slides and stated the following:

> Slides from both lungs showed anthracosilicosis with macule and nodule formation and in some areas focal massive fibrosis are noted. Panlobular emphysema was also present which was consistent with Simple Coal [W]orker's Pneumoconiosis (CWP).
>
> [Miner] has chronic lung disease (COPD) caused entirely by inhalation of coal mine dust. The pneumoconiosis greatly contributed and hastened the [Miner's] death.

(CX 1, 2).

Autopsy Report by Dr. P. Raphael Caffrey

Dr. P. Raphael Caffrey, a board-certified pathologist, reviewed the pathology slides and other records and prepared a consultation report dated February 20, 2004. To the extent that this report is an effort by Employer to impermissibly submit a third medical report, it will not be considered. He reviewed the 18 autopsy slides, noted two micronodules measuring "3-6 mm (0.3-0.6 cm)" in slide M, a moderate amount of anthracotic pigment with a micronodule in slide P, severe pulmonary edema with anthracotic pigment around blood vessels along "with one macule, that is anthracotic pigment with reticulin focal emphysema" in slide Q, and a moderate amount of anthracotic pigment around blood vessels along with one macule in slide R also. He found no evidence of progressive massive fibrosis or bronchopneumonia. Dr. Caffrey reached the following diagnoses:

I. Cardiovascular System
   a. Severe atherosclerosis with approximately 95% occlusion of a section of right coronary artery
   b. Findings consistent with cardiomegaly with minimal increase in myocardial connective tissue

II. Respiratory System
   a. Bullous emphysema, moderately severe
   b. Acute passive congestion of the lungs, moderately severe (left lung 1,163 grams, right lung 702 grams)
   c. Simple coal workers' pneumoconiosis, mild

d. Chronic bronchitis, mild
e. Moderate amount of anthracotic pigment identified in hilar lymph node tissue along with a macronodule

(DX 17-4). The next section of the report includes a review of the Miner's work, smoking and medical history and does not warrant discussion.

In an Opinion section of the report, Dr. Caffrey stated that pathologically, the degree of simple CWP was mild and occupied less than 5 % of the lung tissue, which amount was unlikely to have resulted in pulmonary disability or caused the Miner to quit the coal mines. (DX 17-5 to 17-6). He opined that the simple CWP did not cause, contribute to or hasten the Miner's death. *Id.* He noted with respect to the diagnosis of MI on the death certificate that the Miner had died within minutes of having what was thought to be an MI, and in such a situation the MI changes are not evident in the gross or microscopic autopsy tissue, and an MI was consistent with the 95% occlusion in the right coronary artery. *Id.* He also stated that, as the autopsy was limited to the heart and lungs one cannot tell whether the cancer of the prostate had metastasized, but there was no evidence the cancer spread to the lungs. *Id.* In reaching some of these conclusions, Dr. Caffrey has gone beyond providing an autopsy report and I find that they are entitled to less weight for that reason.

At his deposition, Dr. Caffrey explained the basis for making a pathological diagnosis of coal worker's pneumoconiosis. (EX 7). Much of the deposition involves an attempt to provide a third medical opinion. However, with respect to the cause of death, Dr. Caffrey stated:

> So I don't have any clinical history of what was happening to the patient in the hours or days before he died on May the 29th, 2003, but from a review of the autopsy report and the autopsy slides, this gentleman had severe coronary artery atherosclerosis with almost complete blockage of his right coronary artery; and I believe that he had an acute myocardial infarction or he had ventricular fibrillation, and he died fairly suddenly and had significant congestive heart failure which can happen in minutes time and that's why the lungs were so congested.
>
> So I believe it's certainly possible that he had myocardial infarction. Normally, one needs to live some four to eight hours before the definite gross findings are seen at autopsy after you have an MI, and this man died at home so, obviously, he was autopsied sometime later, on 5-30-03, so I assume he did not live long enough for the findings of a myocardial infarction to be evident either grossly or microscopically.

(EX 7 at 18-19). He further stated that neither he nor the autopsy pathologist found cor pulmonale. (*Id.* at 29).

Medical Report by Dr. Dennis

The autopsy prosector, Dr. Dennis, also prepared a report for the Claimant dated September 20, 2005 (CX 3), in which he filled out a form and responded to questions.[12] Initially, he indicated that the Miner had a chronic lung disease that was caused by his coal mine employment based upon the autopsy. When asked to elaborate on the basis for the diagnosis, he stated: "silica particles cause fibrosis and fibrosis is progressive to PMF [progressive massive fibrosis] & cor pulmonale."[13] On the issue of whether each respiratory condition diagnosed was significantly contributed to or substantially aggravated by dust exposure in coal mine employment, he stated: "PMF – yes – significant, cor pulmonale – caused hypoxia & death." When asked whether the chronic lung condition was causally related, in whole or in part, to the inhalation of coal dust, he stated "Wholly related." Finally, he checked the "Yes" box when asked whether he believed that pneumoconiosis contributed to or played a hastening role in the miner's death, and the rationale he provided was: "PM fibrosis led to cor pulmonale and cor pulmonale led to hypoxia and bronchopneumonia – Cardiac arrest." (CX 3).

Medical Report by Dr. Dale Adkins

A similar form report by Dr. A. Dale Adkins, the Miner's treating physician, was prepared on March 9, 2004. (DX 13-3). Dr. Adkins diagnosed clinical pneumoconiosis based upon the autopsy. On the issue of whether each respiratory condition diagnosed was significantly contributed to or substantially aggravated by dust exposure in coal mine employment, he stated: "progressive significant scarring-fibrosis directly due to coal [?] mine occupation" and when asked whether any chronic lung disease diagnosed was causally related, in whole or in part, to the inhalation of coal dust, he stated "entirely." When asked whether, if coal mining and some other factor caused the chronic lung disease (e.g., smoking) how he could partition the effects, he stated: "Quit tobacco x 25 yrs. Doubt use a factor." By a check mark, he indicated that he believed that pneumoconiosis contributed to or played a hastening role in the miner's death, and the rationale he provided was: "Autopsy finding of coal dust fibrosis COPD [?]."[14] When asked whether he had prescribed home oxygen and why, he stated: "No oxygen [illegible] (on nebulization treatment)." Finally, he stated that he treated the Miner from the 1980's until May 2003. (DX 13-3).

Report and Deposition of Dr. Lawrence Repsher

Dr. Lawrence Repsher, a board certified pulmonologist, was one of the two physicians who rendered opinions on behalf of the Employer. After reviewing the autopsy report and slide interpretations, together with selected medical records, he opined that there was pathological evidence to support a diagnosis of mild simple coal workers pneumoconiosis (but not x-ray evidence of such), that the Miner had bullous emphysema due to cigarette smoking (which he

[12] A similar form submitted with the director's exhibits, dated February 2, 2004, was stricken as cumulative. (DX 13-2).

[13] The Autopsy Report itself (either in its original form or as amended) does not use the term "cor pulmonale." (DX 11, 13).

[14] At Dr. Repsher's deposition, it was suggested that he listed "COPD' instead of "WPD." (EX 6 at 14). A review of the record reveals that, although it looks like "WPD" initially, the "W" is really a "C" followed closely by an open "O." Likewise, the word "coal" in item 3 looks like "WPAI" when initially viewed. (DX 13-3).

based on a 60-year history)[15] and not coal dust, that the bullous emphysema may have caused pulmonary and respiratory impairment but the simple CWP did not, and CWP did not cause, contribute to, or in any way hasten the Miner's death. (EX 1).

Dr. Repsher explained his conclusions further at his deposition. Specifically, he stated the following with respect to the cause of the Miner's death:

> Q. Do you agree with the findings on the death certificate concerning the cause of [Miner's] death?
>
> A. Yes. I have no reason to question the diagnosis of an acute heart attack.
>
> Q. I believe there's some other conditions listed on the death certificate as well.
>
> A. Well, the death certificate states that the heart attack was due to COPD that was due to anthracosilicosis, and there is no connection between coronary artery disease and heart attacks and the presence of either COPD or anthracosilicosis or black lung. Those are independent conditions with no relationship to each other. And cancer of the prostate is not – has no relationship to a heart attack. So I would agree with the diagnosis of acute M.I. but there's certainly no rational basis for saying that the M.I. was due to any lung problem or due to a prostate problem. . . .
>
> . . . .
>
> Q. In your opinion, was [Miner's] death caused by, related to, or hastened by either his coal workers pneumoconiosis or coal dust exposure in any way?
>
> A. In my opinion it was not. There is no relationship between the inhalation of coal mine dust and having a heart attack. . . .
>
> . . . .
>
> Q. Doctor based upon the medical records you reviewed, is there any evidence that [Miner] had any significant respiratory problems before his death?
>
> A. No there isn't. The only evidence we have is that he had mild COPD consistent with his long history of cigarette smoking, but we have no evidence that

[15] Although as noted above, multiple records referenced the Miner's smoking history, or lack thereof, Dr. Repsher apparently was not made aware of these other records. In his report, he stated: "The record reveals one reference to cigarette smoking" (citing the October 7, 2002 admission note of Dr. Swofford, discussed above). (EX 1). It is clear that the Miner was a poor historian but I find no basis for selecting the aberrant 60-pack-year history, which (after taking into consideration the Claimant's credible testimony that he smoked for less than 20 years, ending in 1972) would mean that the Miner smoked three packs per day for 20 years. The other record addressing the amount which he smoked daily stated that it was one pack per day, and yet another record stated that he only smoked for 10 years. It is more likely that the Miner had a 20-pack-year history, based upon consideration of all of the evidence.

he developed any clinically significant COPD, and there's no reason to suspect that he would because he had stopped smoking and he had stopped coal mining.

Q. . . . In your opinion, with reference to the death certificate, are you saying that COPD or anthracosilicosis cannot be conditions that would cause a person's death or, in this particular case, that they did not contribute to death?

A. Oh, no. The COPD is a relatively common cause of death and anthracosilicosis is a relatively uncommon cause of death, but it certainly occurs. And patients certainly die with the combination of COPD and anthracosilicosis. But in this case he clearly died of a heart attack and did not die of the COPD or the anthracosilicosis because both of those conditions were too mild to have any significant effect on his overall health.

(EX 6 at 13-14, 14-15, 17).

Report and Deposition of Dr. Andrew Ghio

Dr. Andrew Ghio, a board-certified pulmonologist, reviewed the records and reached the following conclusions in a report dated March 21, 2004: (1) the Miner suffered from simple coal workers' pneumoconiosis; (2) the Miner's shortness of breath was unlikely to be associated with the CWP due to the limited involvement (approximately 5 % of the tissue involved, based on Dr. Caffrey's estimate); (3) medications included numerous agents directed at chronic obstructive pulmonary disease suggesting that the severity of the disease was greater than just mild; (4) the Miner's clinical presentation and symptoms of shortness of breath, hypoxemia, hyperaeration on chest X-ray, changes in the lung scan, and bullous emphysema on autopsy are more likely to reflect his cigarette smoking that coal dust exposure; (5) respiratory impairment has not been demonstrated so his pulmonary condition is unlikely to have restricted his ability to perform coal mine work prior to his death; and (6) coal worker's pneumoconiosis did not cause, contribute to or hasten the Miner's death which was due to a myocardial infarction (according to the death certificate) or a cardiac arrhythmia (according to the autopsy). (EX 2).

At his deposition, Dr. Ghio discussed the basis for his opinion in more detail.[16] (EX 10). He explained that he worked on the Black Lung program for NIOSH from 1984 to 1986 and he subsequently maintained an interest in the area. (*Id.* at 8.) Dr. Ghio also indicated that he used the inflated 60-pack-year history of cigarette smoking. (*Id.* at 16). On cross examination, he stated that his opinion would change if the Miner had a less than ten pack year smoking history. (*Id.* at 39-40). Dr. Ghio testified that the only one of the Miner's multiple medical conditions (as reflected in the treatment records) that was associated with coal dust was chronic obstructive pulmonary disease but he opined that in the Miner's case there was no association. (*Id.* at 18-19). He further stated that there was no mention of cor pulmonale or findings that would indicate cor pulmonale on the autopsy report. (*Id.* at 19-20). He opined that the panlobular or bullous emphysema was not associated with coal mine dust and he stated that the hyperinflation evident on chest radiographs indicated a form of chronic obstructive pulmonary disease only associated

[16] In considering Dr. Ghio's deposition, I will not consider the portion addressing Dr. Baker's opinion as that opinion is not of record.

with cigarette smoking. (*Id.* at 21-22). He placed more weight on the pathology reviews of Dr. Caffrey and Dr. Roggli than those of Dr. Dennis and Dr. Delara and he stated that for progressive massive fibrosis, "you need a lesion that's larger that 10 millimeters in diameter, or what's deemed to be a coalescence of smaller coal macules into a complicated lesion, and Dr. Dennis has no such description."[17] (*Id.* at 27). Dr. Ghio concluded that the Miner died of a myocardial infarction which had no relationship whosoever to coal dust exposure. (*Id.* at 35).

Complicated Pneumoconiosis

The first issue to be considered is whether the Miner had complicated pneumoconiosis or progressive massive fibrosis at the time of his death. If Claimant can establish complicated pneumoconiosis under the criteria set forth in 30 U.S.C. § 921(c)(3) and §718.304, he is entitled to an irrebutable presumption of total disability due to pneumoconiosis. *See generally Usery v. Turner Elkhorn Mining Co.***,** 428 U.S. 1 (1976) (upholding constitutionality of presumption). Pursuant to §718.304, a claimant may be entitled to the irrebuttable presumption of total disability due to pneumoconiosis, under paragraph (a), based upon a chest x-ray finding of one or more large opacities (*i.e.,* greater than 1 centimeter in diameter) which would be classified as Category A, B, or C under the applicable classification requirements (such as ILO and UICC); under paragraph (b), based upon a biopsy yielding "massive lesions in the lung"; or, under paragraph (c), based upon a condition which "when diagnosed by means other than those specified in paragraphs (a) and (b) . . . could reasonably be expected to yield the results described in paragraph (a) or (b) . . . had diagnosis been made as therein described: *provided, however,* that any diagnosis made under this paragraph shall accord with acceptable medical procedures." §718.304.

These clauses are intended to describe a single, objective condition, and subsection (a) provides an objective standard against which the other subsections can be measured. *See Eastern Associated Coal Corporation v. Director, OWCP [Scarbro]***,** 220 F.3d 250, 255-57 (4th Cir. 2000). The statutory definition of complicated pneumoconiosis need not be congruent with a medical or pathological diagnosis. *Id.* at 257. *See also Double B Mining, Inc. v. Blankenship,* 177 F.3d 240 (4th Cir. 1999) (declining to adopt blanket 2 centimeter rule for pathology findings and instead requiring an equivalency determination to be made); *Handy v. Director, OWCP,* 16 B.L.R. 1-73 (1990) (finding that an x-ray report indicating the absence of small or large opacities consistent with pneumoconiosis, but noting the presence of a 1.0 centimeter lesion in the right lung, was legally insufficient to establish the existence of complicated pneumoconiosis because section 718.304(a) requires a finding of one or more large opacities greater than one centimeter in diameter.) An equivalency determination must be made regardless of whether there is x-ray or pathological evidence of record. *Braenovich v. Cannelton Industries, Inc.*, 22 B.L.R. 1-237 (2003). In *Braenovich*, the Board upheld the administrative law judge's finding of complicated pneumoconiosis based upon his equivalency determination that a 1.5 centimeter lesion on autopsy would produce an opacity of equivalent size on x-ray even though he found both the x-ray evidence and the autopsy evidence to be insufficient to establish complicated

[17] Dr. Ghio did not address Dr. Dennis' finding that: "Macules measuring greater than 3 to 5 cms are appreciated." (DX 13-2; DX 11-1). There are 10 millimeters to a centimeter.

pneumoconiosis, because "'[e]vidence under one prong can diminish the probative force of evidence under another prong if the two forms of evidence conflict.'"[18] *Id., citing Scarbro.*

While the section does not specifically require that a diagnosis of pneumoconiosis be associated with the lesions found, that requirement has been read into the regulation by the Benefits Review Board. In *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (*en banc*), the Board stated that, because section 718.304 offered no opportunity for rebuttal, failure by an administrative law judge to consider all relevant evidence at the invocation stage could constitute a violation of an opposing party's due process rights. The Board held that:

> . . . the administrative law judge shall first determine whether the evidence in each category tends to establish the existence of complicated pneumoconiosis, and then must weigh together the evidence at subsections (a), (b) and (c) before determining whether invocation of the irrebuttable presumption pursuant to Section 718.304 has been established.

The Board noted that CT scans fit under subsection (c). *Id.* In *Braenovich, supra,* the Board indicated that under the Fourth Circuit's mandate in *Blankenship, supra***,** "the administrative law judge is bound to perform equivalency determinations to make certain that, regardless of which diagnostic technique is used, the same underlying condition triggers the irrebuttable presumption."

X-ray evidence.

There is no x-ray evidence of complicated pneumoconiosis. There are three x-ray readings that were designated. The first, an interpretation of an October 3, 1991 x-ray by K.B. Kim, a hospital radiologist, found: "C.O.P.D., otherwise no active cardiopulmonary disease." (DX 14). The other two interpretations, by board-certified radiologists and B-readers Paul Wheeler and William W. Scott, Jr., of the same (August 9, 1995) x-ray found no pneumoconiosis. (EX 4). There are no radiological interpretations positive for pneumoconiosis, silicosis, or progressive massive fibrosis in the medical records. (DX 1, 14, 16).

Pathology evidence.

Of the pathologists, while they all agreed that the Miner had simple coal workers' pneumoconiosis, only Dr. Dennis clearly found progressive massive fibrosis, and then only in his revised autopsy report (and in a supplemental report, where he described it as "significant"). In both autopsy reports, however, he noted macules measuring greater than 3 to 5 cms. He did not provide a basis for me to make an equivalency determination (i.e., indicate what size such

[18] The majority of the Board in *Braenovich* determined that the administrative law judge's determination properly fit under subsection (c) of section 718.304 but the dissent maintained that it should have been considered autopsy or biopsy evidence under subsection (b). Thus, neither the majority nor the dissent applied the *Melnick* requirement of weighing the evidence under all three paragraphs together. The conflict arose in view of the assertion by some of the experts that there is a two-centimeter requirement for a pathological diagnosis of pneumoconiosis whereas there was also evidence that lesions on biopsy would result in approximately equivalent opacities on x-ray.

macules would likely present on x-rays), however. Dr. Roggli indicated that areas at least 2 centimeters in diameter qualify as progressive massive fibrosis, and while he indicated that he did not find PMF on the autopsy slides or reference to findings that would constitute PMF, he did not discuss Dr. Dennis' reference to 3 to 5 cm. macules. Dr. Delara referred to areas of "focal [sic] massive fibrosis" but it is unclear what he was talking about and he did not describe the size of the macules or nodules found. Dr. Caffrey did not find PMF but he described micronodules and nodules, and indicated that two of the micronodules were "3-6 mm (0.3-0.6 cm)" but did not describe the size of any other micronodules or of any nodules at all. In toto, I find that the pathological findings are too unclear for an equivalency determination to be made based upon Dr. Dennis' findings, and the superior credentials of Dr. Roggli add slight weight to his analysis.

Other evidence.

The other reviewing physicians (Drs. Repsher, Ghio, and Adkins) relied upon the pathologist's reviews and their opinions add nothing of substance to the equation.

In view of the above, I find that the Claimant has not established a basis for invoking the irrebuttable presumption under section 718.304 based upon complicated pneumoconiosis.

Contributing or Hastening Factor

As Claimant cannot establish complicated pneumoconiosis, and as it has not been suggested that pneumoconiosis was a direct cause of death, I must determine whether pneumoconiosis was a contributing or hastening factor to the Miner's death. The reviewing physicians all agree that the Miner suffered from simple coal worker's pneumoconiosis. At least one of the physicians expressing an opinion, Dr. Delara, found that the Miner had legal pneumoconiosis (e.g., because his COPD was caused in part by coal mine dust exposure). Thus, I must determine whether the Miner's simple coal worker's pneumoconiosis or COPD due in part to coal mine dust exposure contributed to or hastened his death.[19]

Factors to be considered when evaluating medical opinions include the reasoning employed by the physicians and the physicians' credentials. *See Millburn Colliery Co. v. Hicks***,** 138 F.3d 524, 536 (4th Cir. 1998). A doctor's opinion that is both reasoned and documented, and is supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *See Fields v. Island Creek Coal Co.,* 10 BLR 1-19, 1-22 (BRB 1987) (stating that a "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis, and that a "reasoned" opinion is one in which the underlying documentation is adequate to support the physician's conclusions). In addition, the new regulation appearing at §718.104(d) allows additional weight to be given to the opinion of a treating physician but requires certain factors,

[19] As discussed in the Supplemental Order Clarifying and Modifying Record, Dr. Baker's opinions (CX 4, 5, 10) were excluded because they were submitted as rebuttal to medical opinions, and the regulations do not provide for such rebuttal. Dr. Baker did, however, find both clinical and legal pneumoconiosis. Claimant is not precluded from seeking modification before the district director based on Dr. Baker's opinion. However, she will still have to establish that pneumoconiosis caused, or was a contributing or hastening factor to, the Miner's death.

including the nature and duration of the relationship, the frequency of treatment, and the extent of treatment, to be considered.

Of the physicians expressing opinions in this case, only Drs. Dennis and Delara, both pathologists, and Dr. Adkins, the Miner's treating physician, found that pneumoconiosis was a contributing or hastening factor:

- Putting aside the diagnosis of progressive massive fibrosis, Dr. Dennis found moderate to severe anthracosilicosis, which is a type of clinical pneumoconiosis recognized as such under the regulations. In the autopsy report, he opined that the Miner died as a result of a probable cardiac arrhythmia and pulmonary congestion and edema along with bronchopneumonia. In his form medical report, he opined that the Miner's exposure to silica particles led to fibrosis, which progressed to PMF. He opined that it contributed to or played a hastening role in the Miner's death because the PMF led to cor pulmonale and cor pulmonale led to hypoxia and bronchopneumonia, then cardiac arrest. It is not entirely clear whether this opinion could stand if the finding of PMF were removed, but even if it could, it is flawed because the autopsy report by Dr. Dennis did not reflect cor pulmonale.[20] He did not explain why, if the Miner suffered from cor pulmonale, he did not mention it on the autopsy report.
- Dr. Adkins, the Miner's treating physician from the 1980's until the time of his death, also filled out a form report in which he indicated that the Miner had clinical pneumoconiosis, and that he had significant scarring and progressive fibrosis due to his coal mine employment. He discounted any effect of cigarette smoking because the Miner had stopped smoking 25 years before. However, he did not check the box for legal pneumoconiosis, suggesting that he did not associate the Miner's COPD with coal mine dust exposure. He determined that the pneumoconiosis contributed to or hastened the Miner's death, but his explanation is unintelligible – "Autopsy finding of coal dust fibrosis COPD." Given the lack of reasoning supporting his opinion, I cannot give Dr. Adkins' opinion controlling weight, notwithstanding §718.104(d), even though he was the Miner's treating physician for 20 years.
- Dr. Delara, a pathologist, reviewed the slides and found both anthracosilicosis and "focal massive fibrosis," and he opined that the Miner's panlobular emphysema was consistent with simple coal workers' pneumoconiosis and that he had COPD caused entirely by the inhalation of coal mine dust. He provided no rationale for his conclusion that the COPD was related to coal mine dust. He opined that the pneumoconiosis "greatly contributed and hastened" the Miner's death, but he provided no rationale for that conclusion.

These opinions are all flawed, in that they lack reasoning supporting their conclusions and they lack evidentiary support for their conclusions. I find them to be unreasoned and undocumented.

The opinions submitted by the Employer's experts, while better, are also flawed.

- The pathology opinions of the Employer's pathologists, Drs. Roggli and Caffrey, are well reasoned and documented, up to a point, but neither physician discussed Dr. Dennis' gross findings of macules measuring greater than 3 to 5 cms. Dr. Caffrey opined that

[20] Dr. Ghio, a pulmonologist, indicated that not only did the autopsy report not mention cor pulmonale, but it also did not list findings that would be indicative of cor pulmonale. (EX 2 at 19-20).

simple coal worker's pneumoconiosis did not contribute to the Miner's death, based upon the fact that only 5 % of the lung was affected by it, but he did not really address any possible contribution by COPD based upon his slide review. Dr. Roggli also confined his opinion to whether coal worker's pneumoconiosis contributed to the Miner's death. However, Dr. Caffrey explained how the pathological findings support the finding of a sudden death from an acute myocardial infarction (heart attack) or ventricular fibrillation (cardiac arrhythmia).

- The medical opinions of the Employer's pulmonologists, Drs. Repsher and Ghio, are also well reasoned and documented up to a point. However, both physicians assumed a cigarette smoking history of 60 years, which, as discussed above, is highly inflated and is based upon a selective review of the medical records. Nevertheless, based upon their opinions as to the actual cause of death, their assumption of an incorrect history is not of particular significance. Dr. Repsher opined that the Miner died from an acute myocardial infarction that was unrelated to his COPD, black lung, or prostate cancer. He did not feel that either smoking or coal mine dust was a factor, and he felt that both the COPD and anthracosilicosis were too mild to have any effect on his overall health, or specifically to have affected his heart. Dr. Ghio opined that the Miner's death was due to a myocardial infarction (as stated on the death certificate) or a cardiac arrhythmia (as stated on the autopsy) and that coal worker's pneumoconiosis did not cause, contribute to or hasten the Miner's death. Unlike Dr. Repsher, he opined that the COPD may have been significant and he stated that his opinion would change if the Miner had a smoking history of less than 10 years, as related to the possible contribution by his smoking to the heart attack and heart disease. He did not, however, indicate whether a less than ten year smoking history would change his conclusions about the possible contribution by coal mine dust.[21]

In reviewing all of these opinions, I find that the opinion by Dr. Repsher is the best reasoned and documented. Although he relied upon an inflated smoking history, it is of no consequence as he opined that the Miner's death was unrelated to any lung condition. Rather, he concluded that it was most likely due to a heart attack (acute myocardial infarction) occurring over a matter of minutes, and he further opined that the Miner's COPD and coal worker's pneumoconiosis did not play any part, as a contributing or hastening factor. His opinion is consistent with the well reasoned pathological opinions of Drs. Roggli and Caffrey. While it is inconsistent with the finding in the autopsy report by Dr. Dennis of progressive massive fibrosis, or complicated pneumoconiosis, I have already rejected that finding for the reasons set forth above. Although Dr. Ghio and Dr. Repsher disagree on certain points, they are in agreement that the Miner's simple coal worker's pneumoconiosis did not cause, contribute to, or hasten the Miner's death.

Claimant cannot meet her burden of proof. Specifically, I find that the opinions of the Claimant's physicians, standing alone, are insufficiently documented and reasoned to establish that pneumoconiosis, either clinical or legal, was a contributing or hastening factor to the Miner's death. When the better reasoned and documented opinions of the Employer's physicians are taken into account, it is clear that Claimant has not established her burden of proof. I do not

[21] Although the Miner's smoking history is unclear, and several of the medical records indicate that he never smoked, the evidence of record considered in toto suggests that the Miner smoked for in excess of ten years. This matter is discussed above in footnote 15.

find the credentials of the physicians to be a basis for my opinion (aside from the above discussion of Dr. Roggli's credentials as a pathologist, on the issue of complicated pneumoconiosis) but it is worth noting that the Employer's physicians possess at least as good credentials as those of the Claimant. I also find no basis to assign controlling weight to the Miner's treating physician as his opinion is unreasoned and undocumented.

In view of the foregoing, I find that Claimant has not established death due to pneumoconiosis under §718.205(c), or by any other means.

Conclusion

The record does not establish that pneumoconiosis caused, substantially contributed to, or hastened the Miner's death. Therefore, I find that the Claimant is not entitled to benefits under the Act and applicable regulations.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in the cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to her in pursuit of this claim.

ORDER

IT IS HEREBY ORDERED that the claim of G.A., surviving spouse of E.A., a deceased coal miner, for benefits under the Black Lung Benefits Act be, and hereby is **DENIED.**

A
PAMELA LAKES WOOD
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen H. Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).